CLARK COUNTY
FAMILY AND MEDICAL LEAVE POLICY

EMPLOYEE REQUEST FORM

NAME: _____DATE:_____ EMPLOYEE #: _____

DEPARTMENT: _____ POSITION/JOB TITLE: _____

DATE OF HIRE: _____ STATUS: ❒ FULL TIME ❒ PART TIME

Dates of leave requested: From:_____ To: _____

❒ I request intermittent leave (if applicable.).

Describe the length of each leave period (hours, days, etc.)

_____

_____

Reason for leave:

❒ The birth of my son or daughter and to care for such child;
Expected date of birth: _____

❒ The placement of a son or daughter with me for adoption or foster care;
Date of placement: _____

❒ To care for my spouse, son, daughter, or parent, (circle one) who has a serious health condition;
❒ *Check if parent-in-law.*

❒ My serious health condition
❒ My Worker's Compensation Injury

❒ Other (please explain the reason for the leave):

_____

_____

_____

A PHYSICIAN'S CERTIFICATION WILL BE REQUIRED FOR ALL MEDICALLY RELATED LEAVES.

Substitution of Paid Leave: (Optional if on State leave, required on Federal leave.)

❒PTO _____Hours

❒Compensatory Time _____Hours

❒Cash Balance Vacation _____Hours

❒Cash Balance Sick Leave _____Hours

Comments: _____

_____

_____

I understand and agree to the following provisions:

- ❑ I have read the _____ County policy on administration of the "Family and Medical Leave Acts".
- ❑ I will be financially responsible for my share of monthly medical insurance premiums, if any, and will ensure they are paid promptly as stated in the "Employer Response".
  - ❑ N/A
- ❑ I may be required to exhaust my paid time off or accumulated compensatory time off during my leave.
- ❑ I will be considered to have terminated my employment with Clark County if I do not return to work or contact my supervisor on or before the intended ending date of my leave.
- ❑ I understand that any misrepresentation by me in completing this form may subject me to discipline up to and including termination of my employment and I hereby attest to the truthfulness and accuracy of the above information.

_____ _____

Employee Signature Date

SUPERVISOR'S APPROVAL OF LEAVE REQUEST

❒ I hereby approve the request subject to verification of eligibility.

❒ I hereby deny this request for leave for the following reason(s):

_____

_____

_____ _____

Supervisor Signature Date

APPROVE OR DENY THIS REQUEST AND DELIVER OR FAX THIS DOCUMENT TO THE CLARK COUNTY OFFICE OF PERSONNEL IMMEDIATELY AFTER RECEIPT FROM THE EMPLOYEE.